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ABSTRACT

This staff training manual, the second volume of a three-volume set of materials for use in training paraprofessional refugee workers, deals with the life cycle, mental health, and mental illness, focusing particularly on the unique challenges and pressures of being a refugee. Covered in the individual units are the following topics: psychological development in the first year of life, stages of childhood psychological development, adolescence, age and the life cycle, old age and the care of the elderly, an introduction to the basic concepts of psychoanalysis, an introduction to mental illness, and mental illness in refugees. Each unit contains a list of objectives and instructional text that may include discussion questions. (MN)

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WORKING WITH REFUGEES: A MANUAL FOR PARAPROFESSIONALS

VOLUME II: THE LIFE CYCLE, MENTAL HEALTH, AND MENTAL ILLNESS

BY JOSEPH JAY TOBIN, JOAN FRIEDMAN, AND NANCY LEE KOSCHMANN

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PREFACE

This three volume set of training manuals is intended primarily for the professional development of bilingual, bicultural refugee workers who lack formal training in social services. The manuals are the offspring of the two-leveled training classes we have provided to paraprofessional staff of agencies in Chicago during the past three years. Since these manuals grew out of structured training classes they are ideally suited for classroom use; that is, for use in a setting which allows for a group of trainees to share ideas, to screen films, to participate in exercises (including role-playing) and to benefit from the counsel of a teacher familiar with the course material and the field of refugee social services. However, though a weekly seminar format is ideal, we believe the manuals can also be useful as teaching guides or accompanying texts for agency in-service sessions, as orientation material for new workers, or as a course of self study. Whatever the format, the manuals will be most effective when their content is widely discussed by the workers with each other and with their supervisors.

We should also point out that because the great majority of the refugees resettled by our agency, Travelers Aid/Immigrants Service of Metropolitan Chicago, have come from Southeast Asia, most of our examples concern workers and clients from Cambodia, Laos, and Vietnam. But we believe these manuals will work equally well for people involved in the resettlement of refugees (and to a lesser extent, immigrants) from Haiti, Cuba, Africa, and other cultures, for the issues in refugee adjustment and social services are basically the same whatever the group.

The first volume is an introduction to working with refugees. Topics include accountability, confidentiality, and an overview of the special needs of refugees as clients. The second volume is a review of the life cycle and mental health and mental illness, with a focus on the unique challenges and pressures of being a refugee. This section is a condensation of the material social science majors are exposed to in upper-division undergraduate

psychology, sociology, and social work courses. An understanding of the issues covered in the first two volumes is a prerequisite for the third volume, which as its name explains, is an introduction to interviewing and counseling skills. This volume is intended not to turn paraprofessionals instantly into mental health professionals, but rather to present interviewing and listening skills useful to all levels of social service providors and to prepare and encourage the most talented and interested students to pursue a career as a social service professional. For the time being, in most parts of the country most refugees are dependent on their paraprofessional bicultural workers to meet a wide range of their needs including legal aid, and individual and familial emotional crises. These manuals are designed to enhance the worker's ability to respond to these needs while stressing the importance of referral and knowing one's limitations.

We'd like to acknowledge the contributions of Sandra Young Fried and Tina Birnbaum, both of Travelers Aid, and of Larry Adkison of the law firm of Adkison and Eliot for the chapters they wrote for the manual. And we have a special feeling of warmth and gratitude to Margaret Vodvarka, who has been much more to us than our typist, and to Toby Gordon who has been much more than our editor.

Our greatest debt is owed to the workers who have attended our training classes these past three years. These trainees, who come from many cultures, all have had the kindness and tact to let us play the role of teacher when in fact it is we, the Americans, who all along have had the most to learn. These manuals, like our training classes, are only really of value when workers from another culture combine our American perspectives with their own rich cultural tradition. We place the real creative responsibility on our readers to take from these manuals what is useful, to sort out our errors and cultural biases, and to draw on their knowledge of their peoples and their cultures to produce new syntheses which can enrich us all.

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I PSYCHOLOGICAL DEVELOPMENT IN THE FIRST YEAR OF LIFE

Objectives:

(1) Discuss intrauterine development and stress the need for good prenatal care

(2) Describe the newborn's functioning and the mother-infant bond

(3) Introduce the concepts of ego development and object relations

THE BEGINNINGS OF LIFE

Each infant at birth is already unique, already in small but important ways unlike the other babies sleeping (or screaming) in the cribs alongside him in the hospital nursery. Babies differ at birth because their experiences in the womb differ and, more basically, because of genetic differences. Genes, the biological code inherited from the mother and father, affect the baby's height and weight, his coloring, his ability to fight off diseases, and even aspects of his temperament and intelligence. Genes (heredity) work in combination with life experiences (environment) to make each of us what we are. No matter how tall a baby's parents, he won't be tall if he doesn't have enough to eat when he is growing up. No matter how "smart" a baby's genetic potential, she will be slow in her thinking if she doesn't grow up in a stimulating environment. So to answer the old question, "Which is more important, heredity or environment?" we must say, "both."

Environmental factors start to affect the infant in the womb. During pregnancy the foods the mother eats, her health, and even her mood all affect the baby's development. These environmental effects in the womb are called intrauterine effects.

The fetus will not develop normally in the womb if the mother's health and nutrition are not adequate. Alcohol, medicines (including aspirin), and drugs taken by the mother during pregnancy can cross the placenta from the mother's blood supply to the infant's and cause serious harm. Foods which taste good to the mother may not provide an adequate diet for the fetus. For these reasons prenatal care - which includes periodic check-ups, limiting or, better yet, eliminating smoking, drinking, and drugs, and a good diet - is crucial.

After nine months, or so, the baby is born, and after birth, in America, comes several days in the hospital nursery. Even if the woman is not a first-time

mother, the American way of having a baby can be an unpleasant surprise. It is important to identify those institutions and medical people in your area who perform in ways most compatible with the values held by your clients.

For instance, hospitals differ considerably on issues such as husbands being near wives, rooming-in, help for breastfeeding, length of hospital stay, use of medication, and visitation rights for children and friends. Until recently, separating the infant from the mother soon after birth was routine practice, but new evidence on the importance of mother-infant bonding has now encouraged good hospitals to allow infants to stay with their mothers. In anticipation, it would be useful to provide each woman with a list of helpful English words: baby, fever, labor, push, etc.

Who is this little person the parents bring home from the hospital? The human infant has been described as one of the weakest, least capable, most helpless living thing on earth. But though he is indeed weak and relatively helpless at birth, the infant actually is well prepared to deal with life.

First of all, even at birth, the infant has reflexes. It will be several months before the child really begins to think, to be able to plan, to decide, to evaluate. At birth the child doesn't act, he reacts. These involuntary reaction patterns are called reflexes. The newborn has a grasping reflex (left over from the time long ago when we had to hang onto our mothers as they swung through the jungle trees!), a startle reflex, a rooting reflex (turning the head when the cheek is touched), and, most important, a sucking reflex. These reflexes, particularly sucking, provide the building blocks of infantile motor (movement) and cognitive (thought) development.

What else can we say about the newborn? His senses (hearing, sight, taste) are relatively underdeveloped, his muscles are weak, his nervous system primitive. But these apparent weaknesses actually serve the infant. The weakness of the senses, along with sleeping up to twenty hours a day, help

the infant to screen out the outside world. At birth infants don't seek pleasure. Rather, they avoid unpleasure. They seek equilibrium, a return to a quiet, stable state. When they are hungry, they cry (another reflex) until they are fed, which returns them to their previous state of equilibrium. They can only deal with the world in small doses at first, and sleep allows them to retreat from all the noise and confusion and brightness.

The infant's helplessness and smallness and his pitiful cries are his most important strength, for they make him irresistibly lovable to adults and to his parents in particular. Who can resist a newborn's cry or a two-month-old's smile? Thus the infant's physical helplessness makes him powerful. With a frown or a cry he can send an adult ten times his size running about the house, desperate to serve him.

These cries and smiles are cues, messages sent from infants to adults. Most infants give out the right cues, and most mothers are capable of responding correctly to these cues. Since the infant needs his mother (or another caretaker) to survive, his life is threatened by either an inability on his part to send the proper messages and proper reinforcements or by an inability or unwillingness of the mother to respond to the infant's needs. The strength of the infant is thus really the strength of the infant-mother dyad. A baby who has a deformity, such as a hairlip or a blemish, is at a disadvantage, as some mothers will find it difficult to respond to a baby who doesn't look "cute." A baby with colic, who cries when he's fed, may be rejected by his mother, whose feelings are hurt when she offers her breast to her infant and gets only his cries in return. An infant whose mother is very depressed and preoccupied with her own problems may have difficulty getting adequate attention from his mother. If the mother is very nervous, and the child slow to respond, the mother might become even more nervous, and the relationship can rapidly deteriorate.

Fortunately, most babies send out clear cues and most mothers respond to their infants with love and care. The mother and child soon teach each

other how to get along together. But as caseworkers, you must watch for the occasional mother-infant dyad which isn't working due to a fault in the baby, the mother, or both (bad match of temperaments, for example).

PSYCHOLOGICAL DEVELOPMENT IN THE FIRST SIX MONTHS

During these first few months the infant develops rapidly, building on his reflexes and his relationship to his mother increasingly complex and adequate ways of dealing with the world. As his nervous system develops, he is able to grab things, to put his hands in his mouth, to turn his head, and to follow moving objects with his eyes.

For the first year of life the mouth and the eyes are the infant's most important ties to the world. It is through his mouth and his eyes that he comes to know and to like the world. Infants find pleasure (or relief from unpleasure) mostly in sucking, in eating, and in the feeling of being full. They meet the world with their mouths. Thus, Freud called the first year of life the "oral" stage.

As the infant sucks and becomes full, he looks in the mother's (or other caretaker's) eyes. This gaze is another reflex. Eventually the infant comes to associate the mother's face (and faces in general) with pleasure and soon (around two months of age) the smile develops in the baby as a response to seeing a face.

This is the beginning of object relations, the beginning of the child's relationship to others. It is through feeding and being held that the infant forms a sense that there is an outside world and that this outside world is good. If the mother is inconsistent in her responses to the baby (and especially in how and when she feeds him), the infant will have difficulty developing his ego (sense of self) and object relations (sense of others). If he is fed when he is not hungry, he will have great difficulty developing

into a normal human being, for consistency and love are the lights which lead the infant out of his world of darkness. Care which is consistent but unloving (not tender) will also harm the child greatly. Without consistency and tenderness, infants retreat from life or never even try to enter the emotional world of others. These children are autistic or emotionally retarded. Children who receive care which is just barely adequte in tenderness and consistency will develop but will, according to the psychologist Erik Erikson, leave infancy with a sense of mistrust of people and of the world, as opposed to the sense of trust well-cared-for infants develop in their first year of life.

INFANT CARE

Childrearing theory is guided by cultural assumptions and values. Theory changes as cultures undergo social and economic change. Because American society consists of so many diverse groups, there are numerous - often competing, sometimes contradictory - beliefs about the "best" way to raise children.

For instance, bottle feeding on a four-hour schedule and strict discipline was the 1942 vogue in middle-class America. Among educated young women in 1980, the trend is toward breastfeeding and permissive attention; yet, for others such customs are seen as creating a "dependent" child or characterizing "over protection" on the part of the mother. Attitudes toward babysitters, working mothers, and early introduction of solid foods are examples of Western childraising customs which reflect a cultural value of "independence." Uncomfortableness over public nursing, sleeping with babies and toddlers, or letting small children run around without clothing are possibly indicative of Western discomfort about sexual and bodily functions. The clever caseworker might help the new refugee parent to see questionable customs in a cultural perspective; by conforming in public in such a way as to not cause discomfort to others or embarrassment to the child, most parents can realize a wide latitude of acceptable childrearing patterns.

II STAGES OF CHILDHOOD PSYCHOLOGICAL DEVELOPMENT

Objectives: (1) Introduce the concept of developmental stages

(2) Introduce Piaget's theory of cognitive development

(3) Discuss the concept of separation as an example of a childhood developmental issue which has implications for adulthood as well

We have closely examined the child's psychological development in the first year of life because experiences in infancy for large part determine the kind of child the infant will become, and experiences in childhood determine the kind of man or woman the child will become. To put it another way, "The child is the father of the man."

If an infant is badly cared for, we should be concerned not only about the child's current unhappiness but about his future mental health as well. Bad experiences in the first years of life can plant a seed which can grow into a tangled system of undesirable traits and unhappiness in the adult.

One way of thinking about the connections between early events and later outcomes, of linking the infant with the child and the child with the adult, is by means of a stage theory. Stage theories suggest that, though rates of development may vary from child to child, everyone grows up following the same sequence (order) of stages and that what happens at earlier stages will affect subsequent stages. Stage theories also suggest that development is a series of jumps, followed by plateaus, rather than a smooth, gradual ascent.

The usefulness of a stage theory to us as caseworkers is that it alerts us to look for specific issues, needs, and abilities to appear at certain ages. A knowledge of psychological, social, and cognitive stage theories can help the caseworker to identify blocks, slow-downs, and regressions (moving backwards) in his or her clients' development. Stages give us a sense of what to expect when, a sense of normal development which can help us notice developmental problems and abnormalities.

In subsequent lessons we will examine the stage theories of Erickson and Freud, and we will think about the life cycle as a series of stages. For now, let us look briefly at one very important stage theory of childhood: Jean Piaget's theory of cognitive development. The late Piaget was concerned with intellectual development and how biological maturity related to cognitive functioning and to the ideas (he called them "structures") that a child uses to make sense of the world around him. Piaget's stages are:

0 - 2 YEARS	Sensorimotor	The child is concerned with his body, with what he can touch and manipulate, and with the real objects in the world around him.
2 - 7 YEARS	Preoperational	The child begins to use words and images to think about reality. He tends to think he is the center of the world and has difficulty imagining himself in the place of another.
7 - 12 YEARS	Concrete Operational	The child begins logical thought and can see things in relational terms; he is able to see the reverse of things and put himself in the place of others.
12 YEARS AND UP	Formal Operations	The child can think in abstract terms, reason by hypotheses, and generalize. He becomes interested in ideas, the future, and political, religious, and social problems.

Piaget's work is important because it shows that children of various ages cognitively are not just ignorant versions of adults but rather have distinctive ways of thinking about and interacting with their world.

The chart on the following page is an example of how pediatricians and child psychologists look for certain skills to develop in certain orders, in certain clusters, at roughly certain times. If a seven-month-old child can do all but one or two of the tasks listed for a six-month-old, the doctor or psychologist would not be worried, but if a nine-month-old child still could not do many of the six-month tasks, this would be a cause for alarm, an indication that something is going wrong in the child's development.

Though we know that early events in the child's life can affect the kind of adult he will become, the end results are not easy to predict. It is not

INFANT DEVELOPMENTAL EVALUATION CHART

3 MONTHS

strong cry
sucks and swallows well
reacts to sudden noises
begins to vocalize sounds
smiles

6 MONTHS

laughs aloud
eats a cookie
plays with a toy (rattle)
turns to a voice
reaches for objects

9 MONTHS

waves bye-bye
understands "no"
imitates sounds
recognizes parents
feeds self cracker
plays "peek-a-boo"

1 YEAR

listens with understanding
imitates a variety of sounds
knows "mama" and "dada"
stands without support
marks with a crayon
inserts a spoon in a cup

1½ YEARS

understands simple questions
identifies objects by pointing
points to own eyes, nose, etc.
uses two-word phrases
walks unassisted
feeds himself with spoon

2 YEARS

can point to doll's eyes, etc.
follows directions
names familiar objects
answers, "What does a dog say?"
makes a tower of three blocks
runs well

3 YEARS

holds up fingers to show his age
can count to three
can tell how objects are used
vocabulary of 500+ words
can stand on one foot for a few seconds
can draw a circle
can play imaginatively with others

4 YEARS

can count to five
knows colors by name
vocabulary of 1500 words
can hop on one foot
can draw a man

like cooking: if you put in too much sugar, the cake will be too sweet. It is often easier to see the effects of childhood on the adult retrospectively; we can look back to our childhoods and see when and from where one of our adult characteristics came. For example, a phobia, like a fear of heights, might be connected with a memory of falling out of a tree as a child; or a woman's inability to relate to men can often be associated with bad experiences with her own father as a little girl. But it is much more difficult to realize at the time the child is small just which experiences will turn out to be crucial ones in the development of his personality.

A SPECIAL CONSIDERATION; SEPARATION (suggested film: John)

Let us now look at an example of an early experience (in this case, a two-year-old boy's being left for a week in a nursery) which we might expect to affect later thinking and feeling. We have chosen this example because separation is an important issue for all people, and an especially significant and often painful issue for refugees.

For all of us, no matter how old, separations are very painful. Our ability to cope with them reflects our previous separation experiences as infants, children, and adults.

Over the course of the first six months of life the infant learns to associate his mother's face with pleasures of feeding and being cared for. He becomes attached to his mother (or primary caretaker). He recognizes her. He smiles when he sees her. This attachment means that he now feels a sense of loss when she is not present. The infant experiences separation anxiety. Good mothers help their infants to overcome separation anxiety by providing consistent care. All mothers go away for short periods of time, but they come back, and the child builds up a sense of trust from these experiences of the mother returning.

As the infant becomes a toddler, he becomes more independent. He experiences his growing autonomy as a further sense of separation from his mother. But again, this separation anxiety is overcome by the mother being consistently available for the child to come back to when he gets hurt or frightened. The thousands of experiences of being fed when hungry, picked up when hurt, and held when frightened develop a firm sense of trust and security in the developing child. This trust and security allows the toddler to deal with the feelings of separation and loss he experiences each time his mother goes out, each time he goes off to the babysitter or to nursery school, or when he falls asleep at night. He is confident that even if he or his mother go away, they will be reunited.

If, however, the mother abuses the small child's trust by not returning for a long period of time, the child will experience severe separation anxiety, an experience that may scar and emotionally handicap him for life. As we saw in the film, when a mother leaves a young child for a prolonged period, the child experiences a severe separation reaction which destroys the previous sense of trust and security. The child withdraws from contacts with the world, and when the mother returns, rejects her. When people experience severe loss they protect themselves by rejecting others and hesitating to form new relationships for fear that these too will end in separation.

If children, or adults, experience a series of several traumatic separations from loved ones, they will become withdrawn and eventually unable to relate warmly to others. The only way to help people like this is to be patient and consistently available to them in a supportive way. They must be given a chance to come out of their protective shell when they are ready. They will slowly form new ties to others, and risk future loss, only as they regain a sense of basic trust in the world and a feeling of security.

We can see this syndrome of loss, separation anxiety, lack of trust, and a hesitancy to get close to others in people such as refugees who have experienced traumatic losses in a short period of time. Even for adults, separation and

loss always reawaken painful feelings of rejection. When loved ones die, even adults, unconsciously, may feel angry and hurt, and they may reexperience the child's reaction of "How can you leave me? What have I done to make you go away?" With the help of supportive friends, relatives, and caseworkers, people can overcome these painful feelings, and with time their sense of trust and security can be reestablished and they will be ready to love and risk again.

CULTURE AND CHILD REARING

As we discussed in an earlier lesson, parents of every culture raise their children in distinctive ways which work to produce an adult who is well adjusted to his culture. American parents, for example, use babysitters and place the infant in his own bed in his own room and this tends to produce a child and eventually an adult who is an independent, that is, who is comfortable taking care of his own emotional and physical needs. Asian parents are more likely to have the child sleep beside them and to pamper him more, which tends to produce a child and in turn an adult who is more interdependent, that is, who is comfortable living in a close, extended family setting and turning readily to others for help and assistance. Over many generations each culture develops a set of ideas and rules and theories about how to take care of children, and these theories change relatively slowly, thus giving continuity to cultures from generation to generation. As caseworkers you must be especially sensitive to the problems the refugee parent faces in trying to raise a child in a new culture. The refugee parent brings with him from the old world his culture's parenting style, yet he feels pressured to adjust his parenting style to the demands of a new culture. Some parents stubbornly hang on to everything old, others rush to the new, American ways. You must try to help your clients balance the two.

III ADOLESCENCE

Objectives: (1) Define adolescence as a stage with unique issues and problems

(2) Discuss the physiological changes of puberty

(3) Suggest techniques for working with adolescents

SOME QUESTIONS

What is adolescence?

Does adolescent mean anything more than "teenager"?

What is special about being between the ages of thirteen and twenty?

Is adolescence universal, or is it just an American phenomenon?

What is adolescence like in the cultures of Southeast Asia?

What is adolescence like for teenage refugees and what will it be like for the first generation of Southeast Asian children growing up in America?

And how can we work with adolescents? What help and support can we give them?

TWO CONCEPTS CAN HELP US BEGIN TO SORT OUT THESE QUESTIONS

1. The first is the concept of stages. Developmental psychologists (such as Freud, Erikson, and Piaget) use stage theories to describe and explain the life cycle. A stage theory suggests that development isn't continuous, like the growth of grass, but rather, like going up stairs, it is a series of sudden movements upward followed by resting on a plateau. The order of stages can never be changed, but the rate at which people move from one stage to the next can vary.

   Usually, stages are seen as biologically determined and universal. However, in different cultures and in different times the life cycle is divided up differently. Adolescence is certainly a clearly defined stage in modern American society, but this is a relatively recent American development. And, in many cultures people who would in America be identified as adolescents are

are already functioning as adults (working, getting married, raising families). Adolescence has become continually longer and thus more important in American society. As society becomes more complex, the period of adolescence becomes extended. In America, even people in their twenties often do not marry or enter the work force. Thus cultural factors and economic pressures affect the definition of adolescence as a stage in the life cycle.

2. Another useful and related concept is "critical issues." Stage theories are useful because they allow us to predict, understand, and deal with critical issues which are characteristic of each stage. For each stage of the life cycle there are different critical issues, different challenges which must be met. Thus, for example, Erikson says there are eight ages (stages) of man and each has a critical issue. He says that in infancy the critical issue is trust versus mistrust. For adolescence, Erikson says the critical issue is identity versus role confusion. Another psychologist, Peter Blos, says the critical issue for adolescence is separation; Freud says it's dealing with mature sexual feelings (the return of the Oedipal complex); Piaget says it's the development of abstract thought.

LET'S CONSIDER ADOLESCENCE FROM THREE RELATED PERSPECTIVES:

1. Puberty

Adolescence is usually defined as beginning with puberty. Puberty describes the combination of physical changes boys and girls go through relatively suddenly as they become physically mature. These changes are produced by hormonal changes.

An increase in the male hormones in boys produces increased musculature and body hair, an increase in the size of the genitals,

the onset of sperm production and the potential to have sexual intercourse and thus produce a baby. In girls, female hormones lead to the development of the breasts and a rounding out of the body and to the onset of menstruation (menarche) and the potential to produce a baby.

2. Emotional and cognitive changes

The effect of these male and female hormones is not only physical but emotional as well. Studies show, for example, that the male hormone, testosterone, increases emotional drives for sex and aggression. Female hormones have similar direct links to the emotions. The sudden increase in hormones which occurs with puberty results in adolescents having very strong feelings that they often find difficult to control or understand.

Adolescents are suddenly, following puberty, faced with sexual desires from within which confuse and frighten them. This sudden heightening of the sex drive, in psychoanalytic terms, threatens the previously stable balance between the superego (conscience) and the id (drives and desires). Some teenagers react by favoring the superego and becoming very ascetic, deciding never to marry and to become a nun, for instance. Others favor the id and act out sexually, which is very disturbing to their parents and, on a deeper level, to themselves as well.

The adolescent's emotional upheavel is made even more difficult by the problems of having to get used to his new body. It takes them a while to get adjusted to their new shapes and to develop a good body image. They often feel awkward or ugly in their newly matured bodies. Also, their new bodies produce a change not only in how they see themselves but in how they are seen and treated by others. Adolescent girls have to learn to deal with emotions produced in them by the experience of

being looked at in a sexual way by men. Even their fathers and other male relatives may start to treat them differently and to touch them less once they begin to look like mature women. Adolescent boys may discover that their increased body size makes people look at them differently and perhaps even fear them. The adolescent's internal changes are thus reinforced by the way others treat him or her, producing an even more dramatic emotional upheaval.

Erikson argues that these changes force the adolescent to deal with the challenge of identity. As boys and girls become men and women, they must develop a stable identity, a sense of who they are. This involves developing a secure sex-role identity and a work identity.

Piaget argues that early adolescence is a period of dramatic cognitive development. Around twelve or thirteen years of age most children develop and solidify their ability to think abstractly. This means they can now think about difficult moral and intellectual questions and argue effectively with adults. As they grow older they will continue to gain knowledge but their ability to think and reason will not change.

3. Social

Because of the emotional, physical, and cognitive changes brought on by puberty adolescents are often in conflict with their families and society. Their increased sexual and aggressive drives lead some to crime and sexual acting out (pregnancy, prostitution). In their attempts to separate from their parents and define their own identity, adolescents often overreact and argue with their parents and act rudely with other adults. They then turn to peer groups such as clubs, cliques, sports teams, and gangs for support and identity. Their new ability for abstract thought mixed with their desire to differentiate themselves from their

parents and other adults often lead them to be very critical of society. They are often very reflective, original, and idealistic in their feelings about social change. At other times they are very short-tempered, self-righteous, and destructive. They are old enough to have strong feelings and ideas and still young enough to believe they can change things in society and rectify social inequities.

The generation gap between adolescents and adults is always worse in times of rapid cultural change. Adolescents are always struggling to discover how to function as adults in their society. If things are changing quickly, adolescents will perceive their parents and other adults as "old-fashioned" and "out of touch." They are often right! It is hard for parents to accept their child as an adult and to accept the fact that he or she is different from them. For refugees living in a new and different world this generation gap often is extremely painful for both the parents and the child; the adolescent struggles to balance his old culture and his family's ways with the demands and attractions of life in a new culture he may understand better than his parents.

HOW CAN WE WORK WITH ADOLESCENTS?

As we have seen, adolescence is a stage in the life cycle of rapid physical, emotional, cognitive, and social change. Adolescents, in their struggle to deal with the challenges of sexuality, identity, and separation, often overreact and respond impulsively. This has led some to refer to adolescence as a time of "normal pathology," meaning that extreme behaviors such as delinquency, depression, aggression, and paranoia, which would be quite serious signs of breakdown in other periods of the life cycle, are relatively normal in adolescence.

Thus, to deal with adolescents we should:

1. Remember that many of their extreme feelings and behaviors are normal at this age and will pass if we respond patiently and "stay cool." Confrontations with adolescents will usually just aggravate the problem and will seldom lead to mutual understanding.

2. Don't back adolescents into corners. They feel things strongly, and they tend to see the world in black and white, right and wrong, terms. They will not back down easily, and will feel that it is a matter of pride and independence not to back down.

3. Offer them chances to relate to adults other than their parents. They need adults as role models and they need a chance to sort out their generational differences with adults. A strong adult can often help an adolescent with problems better than the parents can, who are usually too emotionally involved to be able empathize with the adolescent's position.

4. Create and support healthy peer group situations for them. They need a chance to be with other people going through the same kinds of things. They also need a place of their own and a chance to run their own groups, with minimal adult supervision.

IV AGE AND THE LIFE CYCLE

Objectives:

(1) Introduce the concepts of age and the life cycle

(2) Discuss the concept of life cycle transitions

(3) Discuss the special life cycle challenges of refugees

There are many kinds of age:

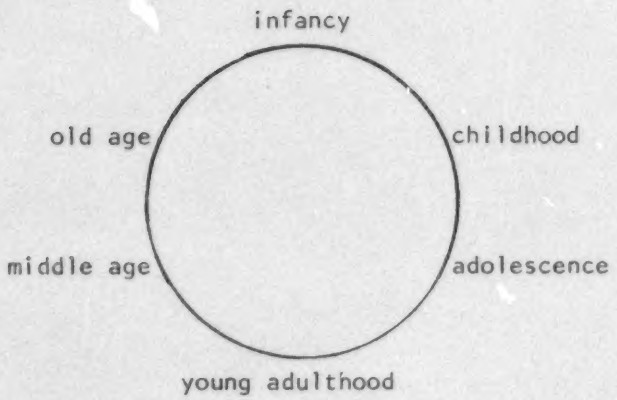
chronological age (the number of years lived)
biological age (physical conditions and development)
psychological/emotional age (emotional development and concerns)
sociological age (roles and relationships in society)
cognitive age (developmental level of thinking structures)
experiental/historical age (events experienced in life)

In every culture, to a greater or lesser extent, at least some of these concepts of age are used to organize social relations and to give structure to individuals' lives. In all cultures people are expected to behave in an age-appropriate manner, to "act their age." Part of our socialization process is the learning of our culture's age norms (what our culture teaches is right and wrong, desirable and undesirable to do and not to do at different ages). As we grow up (become socialized), these age norms become part of us (internalized), and we increasingly use age to help us know what to expect of ourselves and of others.

Age helps us to plan and organize our lives. It is as if each of us wears on our wrist an invisible watch with the time not in minutes and hours but rather in years and decades. And just as a caseworker frequently looks at his watch to decide what he should be doing, so do we all frequently check our "life clocks" to tell us what we should be doing in our family and work lives.

These clocks we carry with us often tell us we are early or late - not to an appointment, but rather early or late in reaching a goal, in passing through an important transition of the life cycle.

The life cycle is divided into stages, and between each stage is a transition. In the West we generally divide the life cycle into:



When we learn to walk and talk we go through the transition from infancy to childhood. When we physically mature and begin to become men and women we go through the transition to adolescence. As we choose an occupation and marry and have children we pass through the transition to adulthood. As our children grow and our youthfulness fades we enter middle age, and when our children move away and begin their own lives, and as we retire from our jobs and become grandparents, we pass through the transition to old age.

Each stage of the life cycle has its own challenges, its own critical issues. The psychologist Erik Erikson has said that their are eight "ages" or stages of man, and eight accompanying "core conflicts."

Erikson suggests that each of these stages must be passed through in order; none can be skipped. He further suggests that what happens during each of the earlier stages will have implications for what will happen in later stages. Thus, a child who fails to develop a sense of trust in the first year of his life is likely to have trouble developing a good sense of autonomy, initiative, identity, and so on later on.

Some of the transitions we go through in the life cycle are smooth; others are sudden and disruptive. A very sudden or disruptive transition is called a life crisis.

ERIKSON'S EIGHT AGES OF PSYCHOSOCIAL DEVELOPMENT

STAGES (AGES ARE APPROXIMATE	PSYCHOSOCIAL CRISES	SIGNIFICANT RELATIONS	PSYCHOSOCIAL MODALITIES	FAVORABLE OUTCOME
1. Birth-first year	Trust vs mistrust	Mother or mother substitute	To get To give in return	Drive and hope
2. Second year	Autonomy vs shame, doubt	Parents	To hold (on) To let (go)	Self-control & willpower
3. Third year-fifth year	Initiative vs guilt	Basic family	To make (going after) To "make like" (playing)	Direction & purpose
4. Sixth year-onset of puberty	Industry vs inferiority	Neighborhood, school	To make things (competing) To make things together	Method & competence
5. Adolescence	Identity vs identity diffusion	Peer groups & outgroups; models of leadership	To be oneself (or not to be) To share being oneself	A good self-image
6. Early adulthood	Intimacy & solidarity vs isolation	Partners in friendship, sex, competition, cooperation	To lose & find oneself in another	Affiliation & love
7. Young & middle adulthood	Generativity vs self-absorption	Divided labor & shared household	To make be To take care of	Production & care
8. Later adulthood	Integrity vs despair	"Mankind" "My kind"	To be, through having been To face not being	Renunciation & wisdom

For the Southeast Asian refugees, the normal life cycle has been disrupted. Refugees lose not only family members, their friends, their occupations, their belongings, and their country but also a sense of order and predictability in their life course. Transitions of the life cycle for the refugees are likely to be sudden and traumatic. And refugees often are likely to feel that they are either very early or very late in reaching crucial stages of their lives. Instead of gradually becoming an adult, many refugees find themselves flung out of childhood or adolescence into adulthood by the untimely death of, or separation from, a parent. Instead of a gradual transition from an active, productive life style into retirement, many refugees prematurely lose their chance to work and their ability to support their family. For many refugees marriage and parenthood may come very late, and retirement and widowhood very early, giving them a very uncomfortable sense of being "off time." Studies have shown that, even for people who have not gone through all of the serious traumas and disruptions the Southeast Asian refugees have faced, it is very important to a sense of well-being to be "on time" in life, and that a sense of being "off time" produces a great sense of discomfort and anxiety.

As caseworkers we can help the refugees by being sensitive to the discomfort and pain they feel by being "off time" and by helping them through their difficult periods of transition.

As Erikson tells us, stages of the life cycle cannot be skipped: at each stage there are issues which must be faced and resolved. So a refugee who has moved too quickly through the life cycle needs to be helped to go back and deal with the issues of a previous stage. And a refugee who has stopped moving through the life cycle (who is fixated) and who has given up needs to be helped to move ahead.

Sometimes we can help our clients by telling them that a conflict they are going through is a natural transition of the life cycle. For example, in a case of a family quarrel over an eighteen-year-old boy's decision to leave

home, we can explain to the parents that the boy is struggling with the problems of the transition to adulthood (with separation and identity problems), and we can explain to the boy that his parents are struggling with the pains of "losing" their child and with the transition to old or middle age, what we call "the empty nest syndrome."

What can we do to help a client who feels hopelessly "off time?" If the refugee is ahead of schedule, and too early, having passed too quickly through stages of the life cycle, we must help him to go back to earlier stages and work them out. Thus, for example, a young man who finds himself suddenly in the role of the leader of his family, following the separation of his family from his father, will need to be helped with the identity problems of adolescence as well as with the adult pressures of supporting a family and raising children. The caseworker can offer him a chance to talk about his feelings about career choice and his long-range dreams and aspirations, even though current pressures in his life may have forced him into prematurely settling into a job he has accepted not of his own choosing.

And for a refugee who feels he is too late, who feels hopelessly behind in the life cycle, we must give encouragement and help to devise a workable plan that will help him catch up. Thus, for example, a twenty-five-year old man who has had his career interrupted and who finds himself unskilled and unemployed must be helped to devise a long-range as well as a short-range vocational plan. Such long-range planning is necessary to restore a sense of order and hope to the life cycle.

Each of us, in conclusion, passes through a life cycle made up of several stages. The transitions from stage to stage are often difficult; we have strong internal clocks telling us to stay on time and not to be too early or too late in our movement through the life course. For refugees, transitions are often more traumatic, and problems of being "off time" are very common.

So, age and age norms are both friends and foes. We sometimes feel age constrains and restricts us but that it also gives our life a sense of pace and order.

What is the ideal age for...

_____ going to a specific doctor

_____ a bride

_____ retiring

_____ becoming a parent for the first time

_____ becoming a grandparent

_____ moving away from home

_____ finishing education

_____ beginning to drink alcohol

_____ stop playing soccer

_____ wearing "sexy" clothes

_____ a man to marry

_____ to stay home without a babysitter

SOME NOTES ON AGE, SOCIETY, AND CULTURE

1. Age and culture

The West is thought of as a culture in which age is relatively unimportant. Many argue that in a culture of rapid change, age and wisdom and experience are less valued than education, initiative, and potential. In a culture like America's, we tend to value what a person can do over who he is or how old he is. Youths often don't respect age. Yet, even in America, we use age everyday to help us decide how to behave and what behavior to expect of others.

In more traditional cultures age is used more obviously to regulate personal and social relations. In many societies there are formal ceremonies (rites of passage) which announce to the society that a person has passed from one stage to the next. The rite of passage tells the person that he must now behave differently and the other members of the society that they must now treat the person differently. Most societies have formal ceremonies for marriage, and many have them for transition into adulthood, for retirement, and so on.

In cultures that value age highly, there are usually special terms, titles, and even special grammatical rules to govern conversations between younger and older people. But even in American society, which seems to be age-free, young people unconsciously use different words to address a Southeast Asian friend than they use in talking to elders.

It will certainly be strange and difficult for people from Southeast Asia to adjust to the absence in American culture of the respect for and attention to age as a means of governing social interactions.

2. Age and society

Societies are made up of people not only of different ages but also of people who have grown up in different times. A group of people who grow up at the same time are called a cohort. The term more commonly used is a generation. The generation gap we find in American society can be seen as a positive phenomenon: cultural change is pushed forward by the conflict between the generations. A sixty-year-old man is likely to see the world differently than a twenty-year-old man not only because he is older but also because he grew up in a different time and in a different environment than the twenty-year-old.

In all societies there are at least some distinctions made between men and women and between the young and the old. To some extent, each of these groups grows up in a different world. The world of a young woman is very different than the world of an old man. These differences may cause misunderstanding at times, but they also make for heterogeneity, which gives the society more vitality.

V OLD AGE AND THE CARE OF THE ELDERLY

Objectives: (1) Define old age biologically, psychologically, and socially

(2) Correct prominent myths about old age

(3) Present ideas for working with aging and dying clients

WHAT IS OLD AGE? WHO ARE THE ELDERLY?

As we discussed in the previous section, there are many kinds of age: chronological, social, biological, emotional, and cognitive. By law, old age in America is often defined chronologically as sixty-five years and older. If we were to define old age socially, in terms of a person's roles, we would think of the transition from middle age to old age as following retirement, becoming a grandparent, and, in many cases, widowhood. Physically, old age is thought of as a period of declining strength, energy, and health. In women, in traditional societies, menopause marks the beginning of old age. Emotionally, old age has been described as a period of "disengagement," a concept we will discuss shortly.

So old age is many different things, and it is defined differently in different cultures. As the average life span lengthens, the definition of old age is also stretched. Is a sixty-three-year-old retired American grandfather who is still healthy and active an old man? If he is old, what do we call a ninety-three-year-old man in a nursing home? Is a sixty-year-old Hmong refugee woman older than a sixty-year-old American woman? As the American life span increases and as the health and activity levels of people in their sixties get better, the need arises for new concepts. Recently the term "young-old," for example, has been introduced to describe people between sixty and seventy-five to distinguish them from the "old-old," seventy-five and older, who have very different problems and very different interests and needs.

There are many myths about old age which further complicate the task of definition. Many people believe intelligence declines with age, but actually only a relatively small percentage of old people (those with a disease commonly called "senility") have marked deterioration of memory and reasoning abilities. Another myth is that old people have no sex drive, but sexual desire and sexual performance can continue well after menopause, well after the age of sixty-five in both sexes. And sometimes we hear old age called a "second childhood." But are old people really like children? Of course not.

Why are there so many myths? Old age is a distant part of the life cycle, a stage none of us have experienced. Since it is distant and unknown, it is easily misunderstood (like a foreign culture!). And since old age is associated with death, we are often afraid of it, and thus we don't give this stage of the life cycle careful study, attention, or clear thought.

DISENGAGEMENT: A THEORY OF OLD AGE

What do we know about the psychology of old age? The study of old age and aging (gerontology) is a young science and thus there are few theories compared to all that has been said and written about childhood and adulthood. One major theory is disengagement. Old people (at least in America) have been observed to have decreased social interactions (less contacts with friends, family, and others, less active roles in society) than middle-aged people. There are two common explanations. One is that old people would like more interaction, that they are like middle-aged people in this regard, but that society pulls away from them. Friends and relatives die, and it is hard to make new friends; people are forced to retire from their jobs, their children move away from the old neighborhood, the neighborhood changes, and the older person is thus isolated against his will. From this point of view, disengagement is abnormal and undesirable. The other explanation suggests that disengagement is a natural emotional process, that as a person ages he becomes ready to pull back from active social interaction, to rest from responsibility, to turn inward and become more reflective, perhaps even to sever ties in preparation for death. Perhaps both views are correct: most people do become more reflective and less active as they age, and most would like to retire eventually. But this doesn't mean they don't want contact with others and they don't miss their children when they move away and their friends when they die. Most old people find the loss of roles and the narrowing of personal contacts very painful. They may welcome retirement, but only if they find something in its place.

AGE AND THE FAMILY IN AMERICA

Asian people, looking at Americans, often wonder, Why don't Americans take care of their elderly parents? Why are old people treated so badly? Why are so many put in nursing homes?

There are many answers. First of all, we must correct another myth. Only 5% of Americans over sixty-five live in nursing homes (or other institutions). Many older Americans in fact do live with family members or, more commonly, in their own homes near family members. Nevertheless, it is true that Americans don't take good care of old people and many people go to nursing homes not because they absolutely need to but because family members won't, or don't know how to, care for them outside of an institution. And the problems of the aged in America seem to be getting worse rather than better.

Americans aren't cold hearted. Americans love their parents. But Americans have always been independent and nuclear family oriented, and our society reflects these values. The immigrants who came to America have always been independent types who often left their parents behind in the old country. Once in America, each new generation moved West, again often saying goodbye to the older generation who were not able or willing to move onto the frontier. In America, the extended family has little or no economic advantage. And in a rapidly changing society the kind of wisdom and knowledge old people have is little valued as ideas and technology radically change with each generation. Old Americans were themselves once young Americans: thus most old Americans, even when lonely, are still independent, and still would prefer to live alone than to share a home with their children. Finally, people in America live to be very old, and by the time they need to move in with others, their children might be as old as sixty or even sixty-five and thus unable to offer energetic care and economic support.

AGE AND SOCIETY

America is also an age-segregated society. People tend not to live in three

generation households. Four-year-olds spend time with other four-year-olds, teenagers with teenagers, old people with old people. There are apartment buildings for young, unmarried, people; suburbs where most everybody is either a school-aged child or a middle-aged parent; and whole communities for retired people where the town's population has an average age over sixty. And the population in America is rapidly aging. The birthrate is down, and the life span is up, with the result that the average age is increasing. By the year 2,000, when the baby boom generation reaches fifty, the majority of people in the country will be over fifty years old! This will place a great strain on the younger generation and the social security system to support the old.

CARING FOR THE OLD-OLD (THE FAILING ELDERLY)

A major worry for refugees, and for all Americans, is how to care for our old people who can't take care of themselves. Nursing homes and other institutions for the elderly care for 5% of people over sixty-five, 15% of people over seventy-five. Many of these people in homes need specialized medical attention (geriatric nurses, doctors, and social workers), and these professionals tend to work mostly in institutional settings. But though the physical care in these homes is generally pretty good, many studies have shown the psychological effects of nursing homes and other "total institutions" to be devastating. Many people rapidly deteriorate emotionally and physically within a few months of entering a home.

But what are the alternatives? Communities like the Japanese Americans in Chicago have worked hard to develop alternatives to the typical American services for the elderly. They provide out-patient geriatric medical and dental services, sheltered workshop facilities, nutrition and exercise classes, support and art groups, "meals on wheels," homebound services, including housekeeping, shopping and medical house calls, and a retirement housing project (see ATTACHMENT A).

The American economic system makes it hard to care for the elderly at home. It's often cheaper to place an aging parent in a government-supported nursing home than to give up a job to stay home and care for him. Financial support for neighbor, or family members willing to help old people clean their apartments and shop, is available in Scandinavia, for example, and helps keep people out of institutions.

We can help those people who need institutionalization. We can help by preparing them for what to expect, by encouraging them to bring familiar things to the nursing home, and by visiting them often and making sure their families and friends visit often, and taking them out whenever possible.

HELPING THE DYING

Sixty percent of Americans die in hospitals, nursing homes, and other institutions. But hospitals and nursing homes are designed not to help people die, but to keep them alive. As a result the staff of hospitals and nursing homes are often unwilling or unable to respond to the needs of the dying elderly. If an elderly woman, for example, who knows she will soon die attempts to discuss her death with a doctor or nurse she will usually be told, "Don't talk that way. Don't give up hope. You aren't going to die." But the dying person knows she is dying, and she is usually better able to accept this fact than the doctors or nurses or family members. A special kind of institution, called a hospice, has recently been developed in America as a last home for the dying. Hospices are staffed by thanatologists, doctors, nurses, and social workers who specialize in ministering to the needs of the dying. These specialists work not only to make death less painful but to help the dying person and his family prepare emotionally for death, and to have a chance to say goodbye. Americans as a people have a deep and strong aversion to facing old age and death, so hospices and the field of thanatology in general are a needed and welcome addition to our medical and social services.

True or false:

_____Americans don't care very much about their aging parents

_____A majority of Americans over sixty-five live in nursing homes.

_____Most people who go into a nursing home die there.

_____The average age in America is dropping.

_____Old people don't care about sex.

_____Intelligence declines in the end of the life cycle.

_____Old people are a lot like children.

_____The elderly received better treatment in Southeast Asia.

_____Doctors and hospitals are well trained to help patients and their families deal with death.

ALTERNATIVE WAYS OF STRUCTURING THE DELIVERY OF SERVICES

A CONTINUUM OF SERVICE:	INDIVIDUALLY DELIVERED	CONGREGATE DELIVERED	
	HOME-BASED	CONGREGATE ORGANIZED	CONGREGATE RESIDENCE
from services for the comparatively well elderly	Out-reach Information & referral Telephone reassurance Friendly visiting Work at home Senior Wheels to shopping, doctor, dentist, & social functions	Adult education Recreational senior center Nutrition sites (Wheels to Meals) Sheltered workshop	Senior housing (includes retirement hotels) Senior housing with recreation Senior housing with recreation & social services
through services that provide alternatives for preventing premature institutionalization	Escort service Homemaker service (housekeeping, handyman, and so forth) Meals on Wheels Home health care (visiting nurse, rehabilitation, speech therapy, dentist, and doctor)	Multipurpose senior center (all of the above plus outreach, and health & social follow-up)	Sheltered care Halfway house
to services for those whose needs may demand institutional care or its equivalents	Foster home care (complete social & health care for bedridden person in a home)	Out-patient day or hospital care	Mental hospital Institutional care (nursing home & home for the aged) Intermediate nursing care Skilled nursing care Short-term crisis care Vacation plan Terminal care

From Sheldon S. Tobin and Morton Lieberman, Last Home for the Aged

VI AN INTRODUCTION TO THE BASIC CONCEPTS OF PSYCHOANALYSIS

Objectives:

(1) To introduce psychoanalysis and place it in its historical perspective

(2) To introduce two psychoanalytic models of the mind

(3) To introduce the concept of compromise formation and to discuss the role memories and the past play in mental functioning

We shall begin our examination of mental health and mental illness with an examination of a major Western model of mental functioning - psychoanalysis. Psychoanalysis is controversial as a method of treatment for mental disorders. But whatever one thinks about the usefulness of psychoanalytic theory, we all need to have an understanding of the basic tenets of psychoanalytic theory to understand Western views of mental illness, for much of our current Western psychiatric theories and techniques grew directly or indirectly out of the work of Sigmund Freud and his "science of psychoanalysis."

Psychoanalysis is a name for:

a therapeutic technique for working with mental problems
a theory about the causes of mental illness
a theory of child development
a theory of normal psychological functioning

Psychoanalysis was developed by Sigmund Freud, an Austrian Jewish physician, in the beginning of this century. Freud was a neurologist who worked with patients who were suffering from hysteria. They had symptoms such as paralysis and blindness which had no apparent organic (medical) cause. Freud learned from a French neurologist, Charcot, that hypnosis could temporarily remove these patients' symptoms. This suggested to Freud that physical symptoms could have an emotional (psychological) basis. Freud further observed that people suffering from hysteria are not consciously aware of the emotional factors in their illness and in fact they consciously believe that their symptoms are entirely physical in nature and entirely out of their control.

Freud, following Charcot, attempted to cure hysterics by hypnotizing them and encouraging them to talk about their problems. This gave temporary relief to the patients, but soon the hysterical symptoms would reappear, since what was learned under hypnosis was forgotten upon awakening. Freud thus abandoned hypnosis and developed what he called "the talking cure," which was the real

beginning of psychoanalytic therapy. He encouraged the patient to lie down and to say whatever came to mind. The patient's free associations led to an understanding for the doctor and the patient of the patient's symptoms, and often this understanding and the process of talking itself seemed to cure the patient of his hysterical symptoms.

From his clinical work with hysterics and neurotics Freud developed a comprehensive theory of psychology. Psychoanalytic therapy has changed considerably since Freud's "talking cure" of the 1890s, and yet the fundamental principles he developed remain valid today. Let's now look at these basic principles of psychoanalytic therapy.

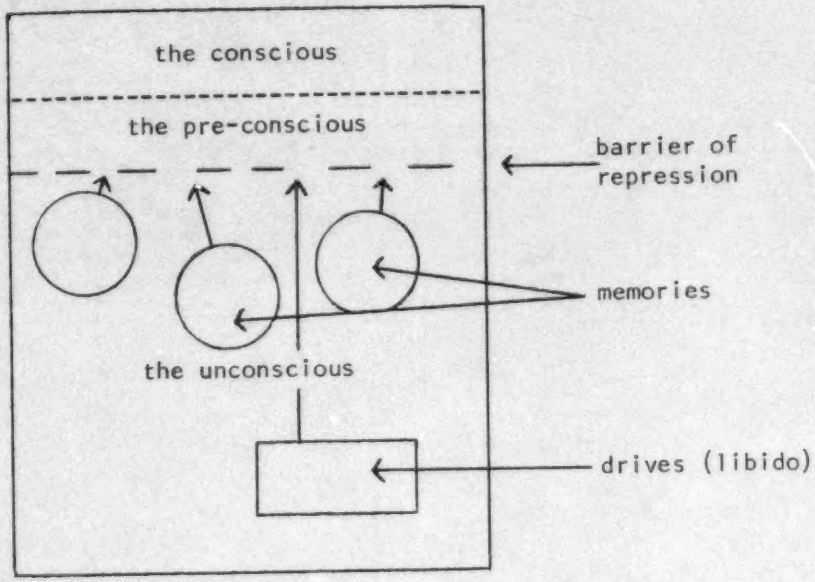
THE CONSCIOUS AND THE UNCONSCIOUS

Psychoanalytic theory teaches us that consciousness, the thoughts we are aware of, are only a small part of our mental activity. The human mind is like a huge, dark house with many rooms, and at any moment our consciousness is like a flashlight lighting up only one corner of one of the many rooms.

Psychoanalysis further suggests that much of the unconscious is unconscious for a reason, that is, the unconscious is composed of both things we don't happen to be thinking about at the time (the pre-conscious) and also things we don't want to think about for some reason.

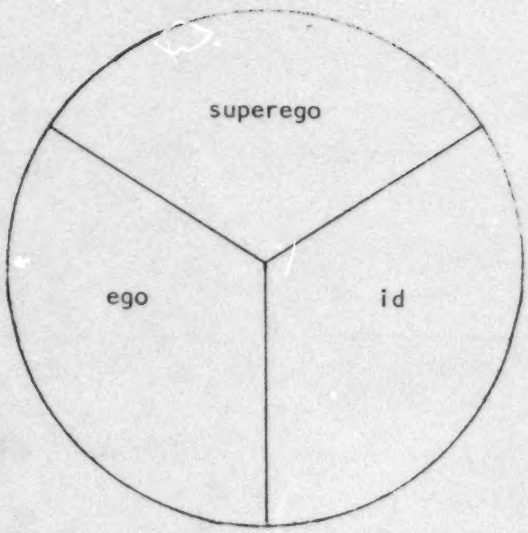
There is a barrier, the "barrier of repression," which keeps painful, embarrassing, disgusting, and confusing thoughts, desires, and memories out of our consciousness. Under certain conditions, such as sleep, hypnosis, and drugged states, the barrier is let down and material from the unconscious comes into consciousness.

Many people have little energy left for life because they use so much psychic energy on defending their consciousness from their unconscious, on holding down the barrier of repression. Many of these people can lead happier, more productive lives by helping them make parts of their unconscious accessible, understandable, and acceptable to their conscious mind.



EGO, ID, AND SUPEREGO

Freud also developed another, complementary model of the mind which suggests that we all have competing forces within us battling for control of our souls. Ego means "I." The ego is our sense of who we are. It is the ego which "decides" what we will do by balancing the demands of the libido (drives, desires) with the conscience and with reality. The id (which means the "it") is the home of the libido, the basic drives for food, sex, and aggression which are part of us all. At birth, the infant is all id, all desire for milk and comfort. As the child grows he gains a conscience, a superego, which is a powerful internal sense of right and wrong, learned mostly from the parents. But since the superego is formed in childhood, it offers a limited, childlike view of right and wrong. Thus, like the id, the superego is a demanding, non-rational voice within us insisting on getting its own way. The ego, which develops during childhood, is what makes us human and civilized. The ego is each of our unique styles and methods of creating compromises between the id and the superego, of setting a course that avoids the dangers of both extremes while keeping an eye fixed on reality.



From this perspective, people with mental problems suffer from an imbalance of ego, id, and superego. If their egos are weak they may be dominated by their ids or by their superegos, or they may swing back and forth between too much and too little gratification of their drives.

COMPROMISE FORMATIONS

Both the id/ego/superego and the unconscious/conscious models of the mind psychoanalysis presents us with involve the concept of compromise formations. The battle between the conscious and the unconscious gives rise to distorted or disguised views of the unconscious, such as we get in slips, dreams, and partial memories. The battle between the id and the superego gives rise to neurotic symptoms which are compromises often failing to satisfy either the original drive or the conscience.

The ego is the ultimate compromiser. The typical patterns of compromise used by the ego are called the ego's defenses. These include:

projection
denial
displacement
identification
reaction formation
intellectualization
repression
sublimation

At one time or other we all use each of these defenses. But, if we come to rely too much on one defense and are too rigid, we become neurotic and unable to adapt smoothly to life's demands. Defenses are so-called because they protect the person from being overwhelmed by his drives, reality, and his conscience. When we fail to do what we know we should do, we rationalize, which is a form of defense. When we are confronted with an unacceptable desire within ourselves, we protect ourselves by projecting the desire onto someone else. The danger comes when we become prisoners of our own defenses, when we find that our defenses are limiting our lives and our ability to respond in a spontaneous manner to our friends, families, and to our work.

THE PAST AND THE PRESENT

Psychoanalysis is often criticized by its detractors for paying too much attention to the past and too little to the present. Although in psychoanalytic treatment much time is often spent discussing childhood memories, psychoanalysts would defend themselves by saying that they are concerned only with those parts of the past which continue to control the person in the present, and that we cannot become free of the past by ignoring it. Painful memories from our pasts reach out of the unconscious to affect our present functioning. If we are happy and productive, we have no need to explore these memories. But if we are unhappy or nonproductive, we need to deal with our past and learn to accept and control our unconscious drives and memories. We are all creatures of habit who have a tendency to respond to new situations in old ways. As we grow and develop, our bodies and our minds change and yet we

retain aspects of the past in what we desire, in what we feel, in how we think, and in how we interact with others. Whatever we experience in our life stays with us always. We cannot lose the past, but we can be helped to be freed from its domination.

Similarily, psychoanalysis is accused of focusing too much on the ugly, on the "animalistic" side of life. Psychoanalysts, however, argue that these drives, whether we like it or not, are part of us all, and that talking about these drives allows us to deal with them more effectively. We are above the animals not because we do not share their basic drives but because we can learn to control these drives and channel their force into constructive forms (sublimation).

CONCLUSION

Psychoanalysis is a significant theory of human development and of the causation and cure of mental illness. Some of psychoanalysis is "old-fashioned," and yet much of it is just as true and useful today as it was fifty years ago. And some of psychoanalysis is culturally limited. Since psychoanalysis was developed by Westerners based on their clinical work with Western patients, we don't yet know much about the applicability of psychoanalysis as a theory and as a therapy for non-Westerners.

Psychoanalysis has formed the basis for much of modern Western psychology. Terms which once were technical psychoanalytic phrases have become everyday expressions, and concepts which were once widely criticized have become accepted and even commonplace. Thus, to understand modern psychological theories and modern therapeutic techniques, it is important to have a good understanding of psychoanalysis.

Psychoanalytic techniques which focus on disclosure are in some ways very unsuited to a Southeast Asian population, but in other, essential ways - such as psychoanalysis' strength in dealing with traumatic memories, psychosomatic symptoms, and its focus on empathy and the use of self in treatment - psychoanalysis has much to offer the Southeast Asian caseworker.

VII AN INTRODUCTION TO MENTAL ILLNESS

Objectives: (1) To define mental illness

(2) To describe the role of the bicultural caseworker in helping clients suffering from mental problems

(3) To introduce the Western diagnostic classification system for mental disorders

WHY DO CASEWORKERS NEED TO KNOW ABOUT MENTAL ILLNESS?

As bilingual resettlement workers, each of you sooner or later will have to deal with clients suffering from mental illness. Clearly, your agency did not hire you with the expectation that you would provide psychiatric care. You have other job responsibilities, and most of you lack the training and licensing necessary for treating the mentally ill in this country. But though you may lack formal training, you are nonetheless an irreplacable link in the mental health care system for refugees.

Ideally, refugees suffering mental health crises would be treated by a bilingual, bicultural psychiatrist, clinical psychologist, or psychiatric social worker. But, as is so often the case in providing services for refugees, reality is far from the ideal. In the real world there are no licensed mental health professionals who speak Hmong, Khmer, or Eritrean, and only a few who speak Vietnamese and Lao. Thus, bilingual, bicultural caseworkers like you are needed to fill the gap created by the absence of bilingual mental health workers.

What services can you provide for the mentally ill client? First you can identify clients who are suffering and need help. As a caseworker you come to know your clients very well. As a bicultural, bilingual worker you are better equipped than anyone else to identify behavior and feelings in your people which are unusual, abnormal, and alarming. Having identified a mental health problem, your next responsibility is to refer your client for help. To refer you must know what mental health resources are available, and you must provide support and information to your client and his family about how they can get help. You may then be called on to interpret (translate) for an American mental health professional. Finally, many of you, despite your lack of formal training, may be asked to provide some counseling to your clients under the supervision of a mental health professional. For now, you need to familiarize yourself with the concepts and terms Americans use to discuss and to deal with mental health problems. In the future, some

of you will need to get advanced training in counseling and treatment so you can directly provide professional, culturally appropriate mental health care to your people.

WHAT IS MENTAL ILLNESS?

Mental illness is called by many different names and it appears in many different forms. In Freud's time hysterical symptoms were common. In the Arctic a woman may tear off her clothes and run off into the snow. In contemporary America a teenage girl may lose her appetite and starve herself to death. A Hmong may believe a spirit has taken over his soul. A Cambodian combat veteran, consumed by rage and guilt, may live in a nightmare of paranoia. But though the form and appearance of mental illness vary widely, people who are mentally ill have something in common: all are in pain; all are suffering; all have a reduced ability to cope with the demands of living; all are experiencing a failure of their psychological defenses (ego functions) to protect them from anxiety. In some cases, the failure of the defenses takes the form of them working too well; the person is dominated by a rigid defensive style with the result that he has a distorted view of the world and a reduced ability to interact spontaneously with others. Freud defined mental health as a life in which the person can work well and love well. Following this definition, we can define mental illness as a reduced capability for living productively (work) and/or for satisfying affectionate relationships to other people (love).

Mental illness is not something that just happens to <u>other</u> people. All of us have the potential to become mentally ill. All of us have friends and family members who in some way and at some time suffer in this way. Everyone has a breaking point; there is no one who copes with endless pressure and unlimited suffering. Thus some people are mentally ill (cannot cope) even under good conditions; others can cope as long as they are not under much pressure; and the very strong manage to cope even under heavy pressure. In other words, all of us are a little mentally ill, a little neurotic, a

little "crazy"; we all distort reality to some degree, fail to control our behavior as well as we might, and have our better and worse days, years, and stages of the life cycle.

A CLASSIFICATION SYSTEM FOR MENTAL DISORDERS

Since mental illness appears in so many forms and in such varying degrees of severity, it is useful to classify mental disorders. Every society has its own classification system. It is important to remember that classifications, or diagnostic categories, as we call them, are just a tool for describing people's symptoms. Labels often do more harm than good if we push people into categories and stop responding to them as complex human beings. Let us look at the standard American psychiatric diagnostic system to familiarize ourselves with how American mental health professionals speak about mental illness. Be careful not to use these categories prematurely with your clients. Leave it to the psychiatrists to diagnose and label mental illness. It is the job of the caseworker not to label his client but to work with him and to let him describe his problems in his own words, using his own categories.

Disorders are divided into functional versus organic. Functional disorders have no apparent, direct physical cause, unlike organic disorders which in a sense are brain disorders, as opposed to mind disorders. Functional disorders are assumed to have an emotional or psychological cause, but this does not mean that there are no genetic or other physical factors which contribute to functional mental disorders.

1. Functional disorders

   (a) Psychoneuroses (neurotic disorders) - these are the less severe disorders, generally not requiring hospitalization, not causing dangerous behavior, and not exhibiting a break with reality.

(i) Anxiety reactions: there is no specific, identifiable source for the anxiety. Often there are physical reactions such as sweating, heart palpitations, and nausea. The person feels very tense and anxious, but doesn't know why.

(ii) Phobias: excessive and inappropriate fears of specific objects and conditions, for example, fear of closed places, animals, germs.

(iii) Obsessive-compulsive reactions: obsessive thoughts, thoughts that can't be controlled, can't be kept out of consciousness. These thoughts are of an unpleasant nature, for example, constant thoughts of a child being injured. These are accompanied by compulsive behaviors - rituals which are irrational but which the person feels he must do, or does without awareness. The compulsive behaviors can be seen as an attempt to control and avoid the obsessive thought.

(iv) Conversion reaction (hysteria): physical symptoms that mimic actual physically caused disorders (for example, paralysis or blindness with no real physical cause). It is thought that these disorders are a result of anxiety being expressed physically.

(b) Psychoses (psychotic disorders) - these are the more severe disorders, often requiring hospitalization, often making the person obviously inappropriate ("off") in his interactions with others, his affect (feelings) and, often, his appearance.

(i) Affective psychosis: exaggerated moods, very depressed, to the point of suicidal thoughts or even action, or very excited (manic). Sometimes there are mood swings from manic to depressive states.

(ii) Schizophrenia: this is the most widespread category. There is distortion of emotions and feelings, often unusual dress and speech and body language, hallucinations and delusions. One form is catatonic, which is little or no movement or expression.

(iii) Paranoia: Delusions are organized into a logical system. Delusions can be of persecution or grandeur, or often of both. The whole system, though false, makes sense from the inside. The person has "proof" to support his system and will defend it logically.

(c) Character disorders - These are disorders of acting in society in an antisocial way, for example, drugs, crime, prostitution. They are associated with a lack of conscience, guilt, and responsibility.

2. Organic disorders (for example, syphilitic brain infection, senility)

Functional disorders are diseases of the mind. Organic disorders are diseases of the brain - injuries or deterioration of the actual brain cell matter. These disorders are much rarer than the functional disorders.

THE CAUSES OF MENTAL ILLNESS

The origins of most mental disorders are poorly understood. It is probably safe to say that a mental disorder is caused by a combination of genetic (constitutional) and environmental factors.

MENTAL ILLNESS AND SOCIETY

People who criticize the government in the Soviet Union are often put in mental hospitals rather than prisons. These dissidents are not called criminals but mentally insane. In fact, these institutionalized dissidents often do become "crazy" from the drugs they are forced to take, the treatment they receive, and the isolation they suffer.

This doesn't occur only in Communist countries. In every society the people with power define what is normal, and people who are different risk being labelled strange, abnormal, neurotic, or even psychotic.

We must thus be careful, in our attempts to help people who are suffering from mental problems, to respect cultural, political, and life-style differences, and not to use mental illness labels as weapons against people.

MENTAL ILLNESS AND SOCIAL WORK

Caseworkers, and social workers in general, can attempt to cure mental illness in two ways: they can either work directly with people who are mentally ill and help them to find new ways to cope or they can deal with the stresses and pressures and inequities in society which contribute to the development of mental illness. In other words, the social worker can attempt either to change the person to live in an imperfect society or to change the society, to make it more hospitable for the people the social worker serves.

As caseworkers working with refugees, we must do both. Certainly there is a significant amount of mental illness and emotional suffering in the refugee population, and some of us have the skills or at least the potential to work as counselors for these people. Others can do more good by dealing with the pressures which weigh so heavily on the refugees and by organizing and supporting community programs and projects which serve as preventive mental health measures.

VIII MENTAL ILLNESS IN REFUGEES

Objectives: (1) Review the concept of culture shock

(2) Introduce the concepts of the trauma syndrome, grief, loss and mourning, and survivor guilt

(3) Discuss the relationship of refugee emotional problems and other categories of mental illness

Refugees experience severe emotional strain; because they endure such suffering and are faced with painful losses, a degree of mental illness is to be expected in the refugee community. Considering the pressures on the refugees, it is amazing how well they have done and how many are functioning well in their new country. But though the majority do well, many others show signs of mental illness.

There are two ways to look at mental illness in the refugee population. We can either use the traditional diagnostic categories of neurosis, psychosis, paranoia, and so forth, or we can think of mental illness in refugees as a special case and use special concepts such as culture shock, trauma syndrome, and survivor guilt.

CULTURE SHOCK

As we discussed in an earlier lesson, culture shock is a very common reaction in people moving suddenly from one culture to another. The symptoms of culture shock (disorientation, fatigue, inability to sleep, mood swings, anxiety, etc.) often look very much like mental illness, but culture shock, unlike mental illness, almost always lasts only a short time; the person suffering from culture shock usually gets better without outside help or professional intervention. Culture shock becomes a cause for alarm and a form of mental illness only when it persists for more than a few months or when it is so severe that it interferes with the refugee's ability to live and work well. When culture shock becomes this severe, we call it "trauma syndrome."

TRAUMA SYNDROME

Don Cohon, who has worked with refugees from Southeast Asia for many years, has written a very important paper on the trauma syndrome[1]; he suggests that

[1]J. Donald Cohon, Jr., "The Trauma Syndrome: Identification, Treatment, and Referral of Commonly Seen Problems," (for copies contact: Pacific Medical Center, Department of Psychological and Social Medicine, 2323 Sacramento Street, San Francisco, California 94115).

refugees with symptoms of mental illness such as severe depression, paranoia, conversion reactions (headaches, stomach disorders), and anxiety be classified as suffering from a unique disease - "trauma syndrome" - and not classified according to the standard diagnostic categories (manic-depressive neurosis or paranoid psychosis or anxiety neurosis following their dominant symptom). Mr. Cohon argues that these symptoms appear as a cluster (thus the word "syndrome") and that they are found frequently in people who undergo severe disruptions and loss, such as earthquake and fire survivors, crime victims, and refugees (thus the word "trauma"). The advantage of conceptualizing refugee mental health problems in terms of the trauma syndrome is that it not only describes the refugee's current functioning but it also explains much about the origin of the illness and suggests a prognosis and treatment for the future. Deep depression in a refugee is of course just as serious as severe depression in a person who has not suffered severe losses, but the refugee with depressive symptoms is more likely to recover than the chronic depressive neurotic, and the refugee probably needs emotional support in a difficult time more than he needs psychiatric intervention (drugs, hospitalization) to get better. The concept of the trauma syndrome should not be used to dismiss the seriousness or uniqueness of a refugee's mental problems, but it should be used to remind us of the special features of the refugee's emotional condition.

SURVIVOR GUILT

One problem we have in dealing with and thinking about the mental problems of refugees is a lack of theories and concepts which speak specifically to the refugee experience. This is one reason Don Cohon's writings on the trauma syndrome are so valuable, and it is one reason why the concept of survivor guilt is so useful to us.

Southeast Asian refugees in general and the Cambodians and Hmong in particular have endured catastrophic losses, but unfortunately their losses are not unique in world history. If we look back forty years to the Nazi holocaust,

we can find a similar situation, and the writings of psychologists and psychiatrists on the mental problems of Jewish concentration camp survivors can provide us with a conceptual model which speaks to the Southeast Asian refugees' condition.

Professionals who studied concentration camp survivors found that often the survivors, after being saved from the Nazis and returned to a life of freedom and safety, continued to be very depressed and troubled and many in fact committed suicide. Therapy with these survivors showed they were haunted by guilt. They were not guilty in the legal sense of having done something wrong but were nevertheless psychologically guilty. They felt as guilty as if they were personally responsible for the deaths of their families, friends, and countrymen. Southeast Asian refugees in 1981 can often be heard saying the same things Jewish survivors said in 1946, things like, "Why should I have lived when my brother, who was a better man than I, died?" and "I should have stayed and died; I'd rather be dead than to live with this guilt and shame and these memories."

We know from the experiences of Jewish survivors that these feelings of guilt can lead to a distrust of self and of others, to paranoia, to self-hate, and even to suicide, and that these feelings can last a lifetime. Even the children of survivors who certainly have no reason to be guilty, feel the effects of survivor guilt; they feel pressured to succeed not only for themselves but also to make up for the losses and the shame of their parents.

LOSS AND GRIEF

Whenever we lose something important to us we experience grief and we need to mourn, to realize what has happened, accept it, say goodbye, and move on with our lives. Refugees have lost not only their loved ones but also their possessions, their language and vocational competencies, and their homeland - with all of its traditions, its climate, and even its look and smell. With so much loss there is enormous grief and the need for a long period of

mourning. But many refugees don't at first have a chance to mourn. As they flee and fight for survival in the jungles and camps they are often too busy struggling to stay alive to deal with their losses. And many are not sure if family members left behind are alive or dead, so they delay their mourning process, holding on to the hope of being reunited someday with the people and things they have lost.

As a result, many refugees experience very strong loss and grief reactions - not when they arrive here but rather six months to a year after their resettlement. For many, only then do the losses become real and only then is there the time and the energy to mourn.

Much of the depression we see in refugees is a natural by-product of the grieving process. Grief and mourning should not be confused with mental illness, for grief and mourning are necessary and natural processes, signs of mental health rather than mental illness. Thus we should be concerned and should consider intervention when a refugee has lost family members and doesn't grieve or when a refugee becomes frozen in the grieving process and continues to be very depressed and consumed by mourning for an abnormally long time.

NORMAL REACTION OR MENTAL ILLNESS?

We need to be aware of the special mental health problems of refugees and to realize that a degree of depression, anxiety, guilt, and paranoia are to be expected in a refugee population. But there is the danger that in expecting refugees to be depressed, anxious, and even a little paranoid we may fail to identify clients who are in fact severely mentally ill and dangerous to themselves or to others. Though expressions of depression and anger are common in our clients, each must be taken seriously as a potential sign not just of culture shock, trauma syndrome, survivor guilt, or loss and grief, but also perhaps of underlying neurotic or psychotic disorders.